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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/30/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Butrans 10mg Sig. Q Week #10

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the use of Butrans 10mg Sig. Q Week #10 is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female with complaints of pain. On xx/xx/xx, she was seen in clinic and was neurologically intact although sensory exam was unreliable. Assessment was lumbar post-laminectomy syndrome. Refill on medications were ordered. On 10/23/14, urine drug screen found the patient positive for fentanyl and hydrocodone and hydromorphone and metabolites of fentanyl. On 01/20/15, the patient was seen back in clinic for complaints of low back, mid back, knee, and ankle pain rated 10/10, during the previous month. Medications included duragesic and hydrocodone. Medications were refilled. On 02/05/15, prescription for Butrans 10mcg patch 1 q week times 10 was written.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 02/13/15, utilization review determination noted the request had been made for Butrans 10mg Butrans. This may be an error for mcg. Peer to peer noted the treating provider indicated Butrans was requested because fentanyl patches were discontinued. There were no plans to detox or wean the patient. This was to prevent withdrawal. Criteria for Butrans patch were not met as there was no detox plan. On 02/25/15, adverse determination for the requested medicine Butrans noted the request was for Butrans 10mcg. There was lack of clinical documentation indicating use as option for chronic pain or detox. Clinical documentation failed to provide clear rationale regarding Butrans for either pain management or detox. There was lack of functional improvement or objective decrease in pain from medication use. The request was non-certified.

This medication may be used for chronic pain or for opiate dependence. For chronic pain, it may be used for patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been

detoxified from other high-dose opioids. The previous determination involved a peer to peer conversation in which it was noted that the provider stated this medication was designed to control pain as the patient had been suddenly disc had apparently been discontinued from fentanyl patch. No detox was noted. Records do not indicate detox was performed for the patient with fentanyl. Therefore, it is the opinion of this reviewer that the use of Butrans 10mg Sig. Q Week #10 is not medically necessary and previous denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)